OPERATIONAL WEBINAR SERIES:

BILLING A CLIENT

WAC 182-502-0160

Copy of this presentation located at
http://www.hca.wa.gov/medicaid/provider/Pages/webinar.aspx

Washington State Health Care Authority

LEARNING OBJECTIVES

As a result of this webinar providers will:

- Understand when a provider can and cannot bill a client for healthcare services.
- Know when a provider can bill a client without HCA form 13-879*.
- Know how to complete HCA form 13-879* and when it is required.

Note: These rules apply to providers who have completed a Core Provider Agreement (CPA) or are contracted with a managed care organization (MCO) to provide healthcare services.

* **Form 13-879** is named "Agreement to Pay for Healthcare Services"

WHY IS THIS IMPORTANT?

Following these rules may protect a provider from:

- Termination of CPA or MCO contracts
- Being excluded from participation in federal contracting, including Medicare
- Audit
- Fraud Charges and Prosecution

WHAT HAS CHANGED?

Effective for dates of service on and after **May 27, 2010**, the Department implemented revisions to Washington Administrative Code (WAC) 182-502-0160, ***Billing a Client***, allowing providers, in limited circumstances, to bill fee-for-service or managed care clients for covered healthcare services, and allowing fee-for-service or managed care clients the option to self-pay for covered healthcare services.

WAC 182-502-0160 can be located at http://apps.leg.wa.gov/wac/default.aspx?cite=182-502

PROVIDER'S RESPONSIBILITY

- Verify whether the client is eligible to receive medical assistance services on the date the services are provided.
- Verify whether the client is enrolled with an Agency-contracted managed care organization (MCO).
- Know the limitations of the services within the client's benefits package (see WAC 182-501-0050 (4)(a) and 182-501-0065) and informing the client of those limitations.
- For various methods to check client eligibility see the *ProviderOne Billing and Resource Guide* (Web address on reference slide at the end of the presentation).

PROVIDER'S RESPONSIBILITY

- Exhaust all applicable Agency or Agency-contracted MCO processes necessary to obtain authorization for a requested service.

- Ensure that translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services.

- Retain all documentation which demonstrates compliance. We also suggest:
  - Document conversation if going to bill client for excluded services.
  - Have client complete your office's financial responsibility form.

DEFINITIONS

Healthcare Service Categories- the groupings of healthcare services listed in the table in WAC 182-501-0060. Healthcare service categories are included or excluded depending on the client's benefits package.

Benefits Package - the set of healthcare service categories included in a client's eligibility program.

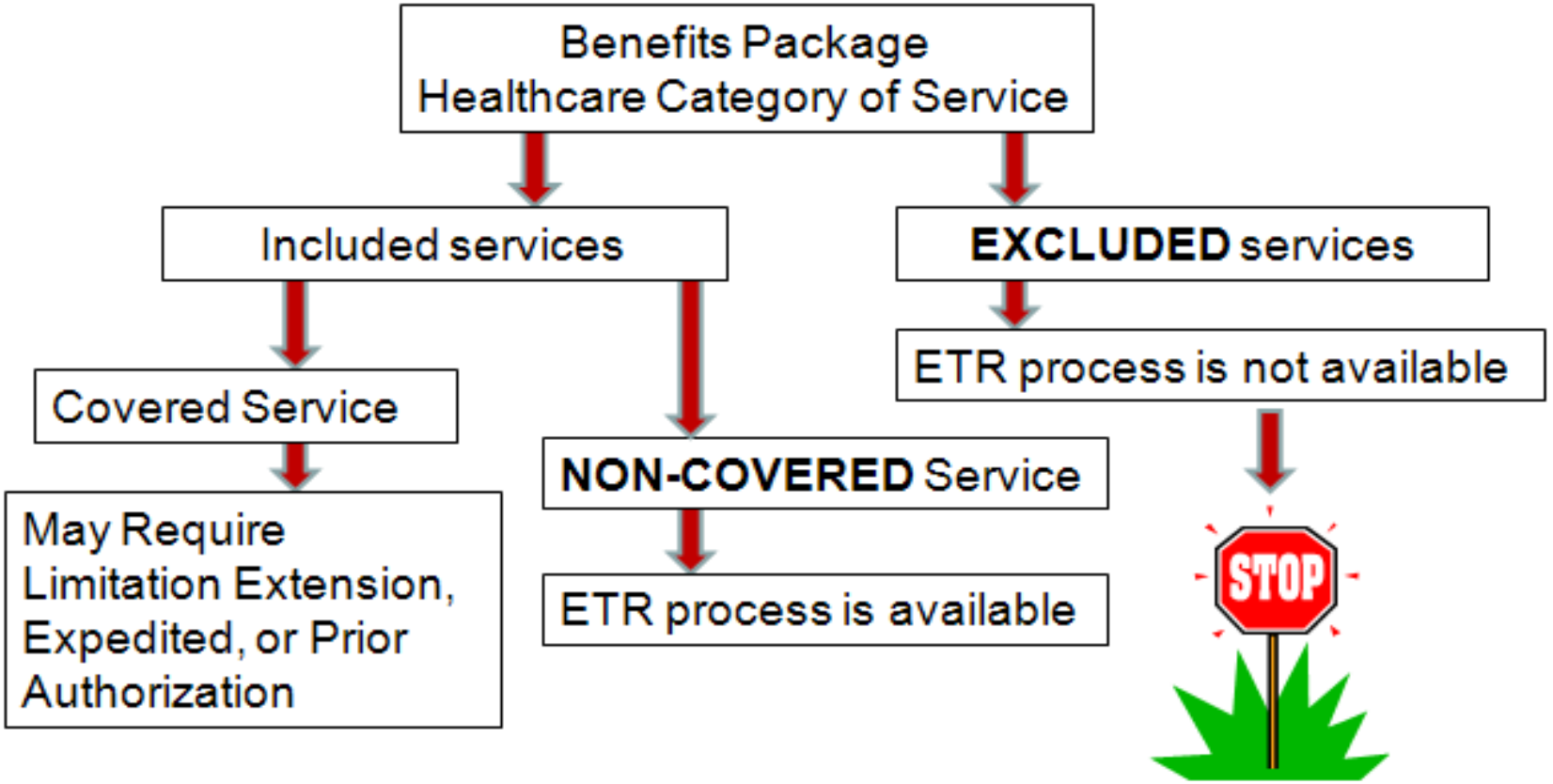
Excluded Services - A set of services that we do not include in the client’s benefits package. There is no Exception To Rule (ETR) process available for these services.

DEFINITIONS

Covered service – is a healthcare service contained within a "service category", that is included in a medical assistance benefits package described in WAC 182-501-0060.

Non-covered service – is a specific healthcare service (for example, cosmetic surgery), contained within a service category that is included in a medical assistance benefits package, for which the Agency does not pay without an approved exception to rule (ETR) (see WAC 182-501-0160). **A non-covered service is not an excluded service** (see WAC 182-501-0060).
Non-covered services are identified in WAC 182-501-0070 and in specific health-care program rules.

NON-COVERED VS. EXCLUDED



Note: The examples in today's webinar are based on Benefits Packages effective January 1, 2011.

NON-COVERED VS. EXCLUDED

Non-Covered	Excluded for Adults* (no funding for these services)
• Cosmetic surgery • Physician services are covered, however cosmetic surgery is not covered under the physician benefits package.	• Adult Dental • Clients participating in the Developmental Disability Program could be exempt.
• Hairpieces or wigs • DME services are covered, however wigs are not covered under the DME benefits package.	• Adult Vision Hardware
• Upright MRI •Diagnostic procedures are covered, but this specific procedure is not covered after a health technology review of its efficacy.	• Adult Hearing Hardware * 21 years of age and older
ETR CAN BE REQUESTED	**NO ETR PROCESS AVAILABLE**

Note: Examples today are based on Benefits Packages effective January 1, 2011.

WHEN CAN A PROVIDER BILL A CLIENT <u>WITHOUT</u> FORM 13-879?

- The client, the client's legal guardian, or the client's legal representative:
  - Was reimbursed for the service directly by a third party; or
  - Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.
- The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a medical assistance program.

WHEN CAN A PRVIDER BILL A CLIENT <u>WITHOUT</u> FORM 13-879?

- The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation (as described in WAC 182-513-1380), emergency medical expense requirement, deductible, or copayment required by the Agency.)
- The client is under the Agency's or a Agency-contracted MCO's patient review and coordination (PRC) program (WAC 182-501-0135) and receives nonemergency services from providers or healthcare facilities other than those to whom the client is assigned or referred under the PRC program.

WHEN CAN A PROVIDER BILL A CLIENT WITHOUT FORM 13-879?

- The services were non-covered ambulance services [See WAC 182-546-0250(2)].
- The services were provided to a Take Charge – Family Planning Service Only (TCFPO) client, and the services are not within the scope of the client's benefits package.
- An Agency-contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO.

WHEN CAN A PROVIDER BILL A CLIENT <u>WITHOUT</u> FORM 13-879?

- A provider can bill an adult client for **excluded** services.

For example:

- Vision hardware
- Hearing hardware
- Non-emergent adult dental

- Please discuss with the client if the service they are requesting is no longer paid for by the Agency

WHEN CAN A PROVIDER BILL A CLIENT WITH FORM 13-879?

- If the service is not covered, the provider must inform the client of his or her right to have the provider request an ETR, and the client chooses not to have the provider request an ETR .

- The service is not covered by the Agency, the provider requests an ETR and the ETR process is exhausted, and the service is denied.

WHEN CAN A PROVIDER BILL A CLIENT WITH FORM 13-879?

- The service is covered by the Agency with prior authorization, all the requirements for obtaining authorization are completed and was denied, the client completes the administrative hearings process or chooses to forego it or any part of it, and the service remains denied by the Agency as not medically necessary.
- The service is covered by the Agency and does not require authorization, but the service is a specific type of treatment, supply, or equipment based on the client's personal preference that the Agency does not pay for. The client completes the administrative hearings process or chooses to forego it or any part of it.

WHEN CAN A PRVIDER NOT BILL A CLIENT?

The HCA form does not apply in these scenarios:

- Services for which the provider did not correctly bill the Agency or MCO.
  - Directions on how to bill the Agency can be located in the *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html
  - For directions on how to bill the MCO please contact the plan directly.
- If the Agency or MCO returns or denies a claim for correction and resubmission, the client cannot be billed.

WHEN CAN A PRVIDER NOT BILL A CLIENT?

- Services for which the Agency or MCO denied the authorization because the process was placed on hold pending receipt of requested information but the requested information was not received by the Agency. (WAC 182-501-0165(7)(c)(i))
  - This includes rejected authorizations, when the authorization request is returned due to missing required information.
- The cost difference between an authorized service or item and an "upgraded" service or item preferred by the client (e.g., a wheelchair with more features; brand name versus generic drugs).
- Providers are not allowed to “balance bill” a client.

WHEN CAN A PROVIDER NOT BILL A CLIENT?

- Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in chapter 70.02 RCW, to another healthcare provider, which includes, but is not limited to:
  - Medical/dental charts
  - Radiological or imaging films
  - Laboratory or other diagnostic test results

- Missed, cancelled, or late appointments

- Shipping and/or postage charges

WHEN CAN A PROVIDER NOT BILL A CLIENT?

- Services for which the provider has not received payment from the Agency or the client's MCO because the provider did not complete all requirements necessary to obtain payment; (example: billing using a diagnosis code which is not a primary diagnosis code per ICD-9).

- "Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care.

FORM 13-879

Washington State Health Care Authority

Agreement to Pay for Healthcare Services

WAC 182-502-0160 ("Billing a Client")

This is an agreement between a "client" and a "provider," as defined below. The client agrees to pay the provider for healthcare service(s) that the Health Care Authority (HCA) will not pay. Both parties must sign this Agreement. For the purposes of this Agreement, "services" include but are not limited to healthcare treatment, equipment, supplies, and medications.

Client - A recipient of Medicaid or other healthcare benefits through the HCA or a managed care organization (MCO) that contracts with the HCA.
Provider - An institution, agency, business, or person that provides healthcare services to HCA clients and has a signed agreement with the HCA or authorization from an MCO.

This Agreement and WAC 182-502-0160 apply to billing a client for covered and noncovered services as described in WAC 182-501-0050 through WAC 182-501-0070. Providers may not bill any HCA client (including those enrolled with an MCO that contracts with the HCA) for services which the HCA or an MCO that contracts with the HCA may have paid until the provider has completed all requirements for obtaining authorization.

CLIENT'S PRINTED NAME	CLIENT'S ID NUMBER
PROVIDER'S PRINTED NAME	PROVIDER NUMBER

HCA electronic forms can be located at
http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx

FORM 13-879

SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE	CPT/CDT/ HCPC CODE (BILLING CODE)	AMOUNT TO BE PAID BY CLIENT	REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)	COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT	DATE(S) ETR/NFJ REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED, IF APPLICABLE	
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Non-formulary drug, NFJ waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for ☐ Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)

- I understand that HCA or an MCO that contracts with HCA will not pay for the specific service(s) being requested for one of the following reasons, as indicated in the above table: 1) HCA does not cover the service(s); 2) the service(s) was denied as not medically necessary for me, or 3) the service(s) is covered but the type I requested is not.
- I understand that I can, but may choose not to: 1) ask for an Exception to Rule (ETR) after an HCA or HCA-contracted MCO denial of a request for a noncovered service; 2) submit a Non-Formulary Justification (NFJ) with the help of my prescriber fro a non-formulary medication; or 3) ask for a hearing to appeal an HCA or HCA-contracted MCO denial of a requested service.
- I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by the HCA or an HCA-contracted MCO, and I still choose to get the specified service(s) above.
- I understand that HCA does not cover services ordered by, prescribed by, or are a result of a referral from a healthcare provider who is not contracted with HCA as described in Chapter 182-502 WAC.
- ***I agree to pay the provider directly for the specific service(s) listed above.***
- I understand the purpose of this form is to allow me to pay for and receive service(s) for which HCA or an HCA-contracted MCO will not pay. This provider answered all my questions to my satisfaction and has given me a completed copy of this form.
- I understand that I can call HCA at 1-800-562-3022 to receive additional information about my rights or services covered by HCA under fee-for-service or managed care.

I AFFIRM: I understand and agree with this form's content, including the bullet points above.	CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE	DATE
I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-502-0160.	PROVIDER OF SERVICE(S) SIGNATURE	DATE
I AFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above.	INTERPRETER'S PRINTED NAME AND SIGNATURE	DATE

TIPS FOR COMPLETING FORM 13-879

- The form must be completed within 90 days before the service is provided for which the client agrees to pay.
- Keep the original agreement in the client's medical record for 6 years from the date the agreement is signed.
- A copy of the signed agreement must be given to the client.
- This form is available in 8 different languages. Use the appropriate version for non-English speaking clients.
- Use an interpreter as indicated to assure client understands situation, options and makes an informed decision.

SCENARIOS

An adult client sees a dentist complaining of pain of the back teeth on the left side of the face. The dentist makes recommendations for what can be done under the emergency oral health care services benefit or a root canal – an excluded service. The client chooses the root canal.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

SCENARIOS

An adult client sees a dentist complaining of a symptom that qualifies for a service from the emergency oral healthcare benefit. The client chooses a root canal from the list of treatment options made available by the dentist.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

The answer is B!

A form should be completed because the Agency will cover emergency oral healthcare services and one of these services were offered, but the chosen root canal is excluded. If the client chooses the excluded service over a covered service HCA form 13-879 must be completed.

SCENARIOS

A new client comes in for an appointment and documents they have no insurance on their paperwork.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

SCENARIOS

A new client comes in for an appointment and documents they have no insurance on their paperwork.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

The answer is A!

A client who represents themselves as a self pay patient can be billed without the HCA form. Keep the documentation in your records.

SCENARIOS

A provider's claim is denied by the Agency for missing or invalid taxonomy.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

SCENARIOS

A provider's claim is denied by the Agency for missing or invalid taxonomy.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

The answer is C!

Clients cannot be billed for denied claims that need to be corrected and resubmitted to the Agency.

SCENARIOS

An adult client with the Limited Casualty Program – Medically Needy Program (LCP-MNP) Benefits Service Package goes to see a physical therapist. Physical therapy is excluded from the MN benefits package.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

SCENARIOS

An adult client with the Limited Casualty Program – Medically Needy Program (LCP-MNP) Benefits Service Package goes to see a physical therapist. Physical therapy is excluded from the MN benefits package.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

The answer is A!

Clients can be billed for excluded services without completing HCA form 13-879.

SCENARIOS

A new client comes in for an appointment, states he or she has Medicaid, but does not have their Client Services card available.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

SCENARIOS

A new client comes in for an appointment, states he or she has Medicaid, but does not have their Client Services card available.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

The answer is C!

There are many other options to check eligibility other than using the ProviderOne Client Services Card. Please visit the *ProviderOne Billing and Resource Guide* for more information on checking eligibility.

SCENARIOS

An adult client goes in for a routine physical with no medical concerns.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

SCENARIOS

An adult client goes in for a routine physical with no medical concerns.

Can the client:

a) Be billed without HCA form 13-879
b) Be billed with HCA form 13-879
c) Not be billed for this service

The answer is B!

Some services during the exam may be covered, such as a PAP, but the exam may be non-covered if there are no conditions that can be documented with a diagnosis code, and the bill will be submitted with a “V” code, e.g., “general exam”. A client can be billed for these services with a signed waiver.

REFERENCE GUIDES

General Information about Medicaid

- Summarized in the ProviderOne Billing and Resource Guide http://www.hca.wa.gov/medicaid/provider/Pages/providerone_billing_and_resource_guide.aspx
- See the Provider Training web site for links to recorded Webinars, E-Learning, and Manuals http://www.hca.wa.gov/medicaid/provider/Pages/webinar.aspx
- See the forms web site for all forms http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx
- All the Washington Administrative Codes (WAC) can be found at http://apps.leg.wa.gov/wac/